CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COMP	(X3) DATE SURVEY COMPLETED 05/24/2011	
	PROVIDER OR SUPPLIER		586 EA	ADDRESS, CITY, STATE, ZIP COD STERN BOULEVARD (SVILLE, IN47129	Ε		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F0000							
	This visit was Complaint IN(	for Investigation of 00090791.	F0000				
	Complaint INO Substantiated. deficiencies re allegations are and F9999.	Federal/state					
	Survey dates: 5/23 and 5/24/11						
	Facility number Provider number: AIM number: Survey team:	per: 155165					
	Census bed typ SNF/NF: 112 Total: 112	oe:					
	Census payor 1 Medicare: 20 Medicaid: 91 Other: 1 Total: 112	type:					
	Sample: 3						
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE	

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:

26RH11

Facility ID:

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY  COMPLETED
ANDILAN	OF CORRECTION	155165	A. BUILDING	00	05/24/2011
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>
	PROVIDER OR SUPPLIER		<b>I</b>	STERN BOULEVARD	
RIVERVI	EW VILLAGE		CLARK	SVILLE, IN47129	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE DATE
F0221 SS=D	accordance with 410  Quality review compaulkner, RN  The resident has t	eflect state findings cited in DIAC 16.2.  pleted on June 1, 2011 by Bev  the right to be free from any imposed for purposes of			
30-0	discipline or convetered the resident's Based on obserview, and infailed to ensurand care plann of the least and restraint. The ensure care planed are to related to release during meal timpractice affector reviewed relates sample of 3. (Findings inclusion.)	enience, and not required to a medical symptoms. rvation, record terview, the facility e resident assessment ing supported the use d most effective facility also failed to ans were followed ase from the restraint me. The deficient ed 2 of 2 residents ed to restraints in a Residents C and B)  de:	F0221	F221 Physical Restraints It is practice of this facility to ens residents are free from any physical restraints imposed the purpose of discipline or convenience and not require treat residents medical symptoms.1. What corrective action will be accomplished those residents found to have been affected by the deficier practice. Resident C and B careplans/C.N.A. assignments were revised to include "Release seatbelt at Mealtim instead of "May release seat at Mealtimes" (indicates this information on the changes I above. Resident C and B were-assessed on 6/6/11 utilizing "new" Pre-Restraint Assessments Both residents will continue use of their seatbelts. Residents	for ed to e for re for re to to tde nes" tbelt is vere isted re ng a ment. the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155165	B. WIN			05/24/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	ę.		586 EAS	STERN BOULEVARD		
	IEW VILLAGE			CLARK	SVILLE, IN47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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		ecured unit, Resident			are reviewed every 30 days I the IDT for ongoing use of a	ОУ	
	1	ed at the dining table		physical restraint.On 5/16/11 the			
	seated in a wh	eel chair. During			families of resident B and C		
	interview at th	nis time, CNA #6			educated on the use of restra and the risk involved. Both	aints	
	indicated the i	resident wore a seat			families were agreeable and		
		nterview at this time,			voiced understanding of the		
	1	ated the resident had			involved. The rapy re-screene 6/6/11 resident C and B to	d	
	had multiple f	alls and it was felt a			determine if other interventio	ns	
	had multiple falls, and it was felt a seat belt was best for the resident.				could be used. Therapy valid		
					the use of the seat belt for bo	-	
		ated the resident was			resident C and B and deeme seatbelt as the least restrictive		
	doing well wi	th the seat belt, which			device.In-services were	. •	
	was considere	d a restraint for him.			conducted with the Nursing s		
	LPN #7 indica	ated the resident can			on the Falls Prevention Prog	ram	
	get up and wa				and Gait Belt Policy. The in-services included Post tes	ts to	
	get up and wa	IX.			ensure staff understanding.		
	0 5/22/11	6.55 D : 1			In-services were conducted of		
	1	6:55 p.m., Resident			5/31/11 by the Staff Develop	ment	
	C's wheel cha	ir was removed from			Coordinator.2. How will you identify other residents havin	a the	
	behind the tab	le, and LPN #7 asked			potential to be affected by the	-	
	if he wanted to	o walk. Using a gait			same deficient practice and v		
	1	and CNA #8 assisted			corrective action will be taken.Two additional residen	te	
	1 '	stand, and the			were identified with restrictive		
	1	ssisted to walk with			devices. The Inter Disciplina	ıry	
		d tiny shuffling steps,			Team(IDT) reviewed both residents careplans and C.N	^	
	1				assignment sheet and revise		
	"	y back, with the staff			indicated.The IDT team evalu		
	pulling up at the gait belt and holding under the resident's arms.  Staff asked the resident if he was getting tired, and he was assisted to				resident(s) for a restraint and		
					prior interventions attempted when the decision has been		
					made to utilize a restrictive		
					device.3. What measures wil		
	1 -	chair, and then			put into place or what system		
		chair, and then			changes you will make to en	sure	

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(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
		ck to his wheel chair,		that the deficient practice do not recur. A new Pre-Restrai	ı
	and the seat b	elt was fastened.		Assessments were complete	
				residents C, B and the other	I
	During observation on 5/24/11 at			residents which included us	
		sident C was observed		prior interventions attempted Revisions were made to the	I
	_			of care and C.N.A. Assignm	· .
		ning room chair at the		Sheets as indicated.Nurses	ı
		ning room of the		Inter Disciplinary Team(IDT)	
	secured unit.	CNAs #10 and #12		re-educated on 5/31/11.The evaluates residents for a res	
	were observed	d assisting Resident C		and prior interventions atten	I
	to transfer the	resident to his wheel		when the decision has been	
	chair, and the	seat helt was		made to utilize a restricitve	
				device.The DNS is responsi monitor program for	ble to
		ring interview at this		compliance.4. How the corre	ective
	i i	0 indicated the		action will be monitored to e	ensure
		eel chair was a		the deficient practice will not	
	temporary one	e used to keep him		recur, i.e., what quality assu program will be put into place	
	safe. CNA#1	0 and CNA #12 were		DNS will complete the Phys	
	observed trans	sferring Resident C to		Restraint CQI tool for 4 wee	ks
		ng interview at this		and monthly for 12 months.	
	· ·	~		CQI committee reviews the and if thresholds are not me	ı
	·	As indicated the		action plans are developed	
		leclined greatly since		improve performance and	
	his hospitaliza	ation.		determine need for further a	
				Non-complinace with facility procedures may result in	
	The clinical re	ecord for Resident C		re-education and/or discipling	nary
	was reviewed	on 5/24/11 at 2:05		action.	
	p.m. The record indicated the resident was admitted to the facility on 4/8/10 with diagnoses including,				
	but not limited	d to, dementia.			

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	was discharged on 3/29/11 and facility on 4/6/ Fall Circumstatindicated the r	ance Reports					
	unwitnessed fadoorway with "going to bath 10:00 p.m., and the resident's runassisted transp.m., and witnessisted t	all in the bathroom the resident falling room;" 4/20/11 at a unwitnessed fall in room during asfer; 4/23/11 at 2:45 ssed fall with no dining room; and					
	dated 5/16/11, the medical sy that led to the Unsteady gait/ cognition r/t [r	straint Assessment, indicated, "What are mptoms/diagnosis use of a restraint? 'balance, impaired related to] dementia. for physical restraint:					

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	Res. to be [arrow/C [symbol seatbelt r/t unsimpaired cogn hour, release expected applicable interested applicable interested applicable interested initiation." Medication remeasures, Toil Behavior mana Handwritten a involvement. Lowering bed mattress, Posit Trapeze, Self-supervision, Decushion, Bed a and Sensor ala also indicated device assists reaching his/hophysical and pfunctioning by risk from injuring	ow pointing up] in for with] front closure teady gait, balance, ition. Check every very 2 hours for es of daily living]. or meals, activities & onCheck all erventions used prior Checked were: view, Restorative eting program, and agement. It Other was: Therapy Unchecked were: to floor, Concave tioning side rails, release belt, Direct trop seat, Wedge tharm, Chair alarm, rm. The assessment the "restrictive the resident in er highest level of sychosocial red Decreasing his/her ries."					
	A riiysicai Th	erapy Discharge					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

26RH11

Facility ID:

000082

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE SURVEY COMPLETED		
	or condition	155165	A. BUI B. WIN	LDING		05/24/20	
NAME OF E	PROVIDER OR SUPPLIER		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
				1	STERN BOULEVARD		
	EW VILLAGE				SVILLE, IN47129		
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	Summary, date	ed 5/17/11, indicated,				ĺ	
	"Res DC [disc	harge] as he was not					
	making any pr	ogress. Res. is in a					
	WC [wheel ch	air] now due to					
	multiple falls v	which are due to					
	decline in cogi	nitive and medical					
	condition."						
	During interview and request for						
		s on 5/24/11 at 4:00					
	_	pational Therapist					
	_	er indicated she could					
	not locate info	rmation about use of					
	the wheel chai	r for Resident C,					
	except as indic	cated in the discharge					
	summary. She	e indicated she					
		iscussion about					
	whether the re	sident would be safer					
	in the chair or	not. She indicated					
	she remember	ed they did not want					
	to use a seat be	elt for the resident,					
	because they v	vould be concerned					
	about his safet	y. She indicated if					
	the resident tri	ed to stand while in					
	the seat belt, the	nat could cause					
	tipping and car	use him to fall.					
	The Restraint	Care Plan, dated					
		ated Interventions					
	5/10/11, marca	aca interventions					

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	PROVIDER OR SUPPLIER		STR 586	EAST	PRESS, CITY, STATE, ZIP CODE ERN BOULEVARD ILLE, IN47129		
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	including, but "Restraint redu remove restrait time."  2. During Initial 5/23/11 at 5:35 p Manager, indica previously and w #3 indicated the resulted in a "bra indicated the resi belt on her reclin  On 5/23/11 at 5:5 observed pushing hallway. The res gerichair. The re have a raised pur of a golf ball to t forehead. The si	not limited to, action plan is to nt: During meal  Tour of the facility on .m., RN #3, Unit ted Resident B had fallen ras at risk for falls. RN resident's most recent fall in bleed." RN #3 dent now wears a seat er.  55 p.m., CNA #4 was g a resident down the sident was reclined in a resident was observed to plish area about the size he left side of the de of the face was					
	of the cheek. RN resident was Res indicated she need bed. When the resolution rolled next to the observed to be when the clinical recovery reviewed on 5/24 record indicated	he forehead to the bottom I #3 indicated the ident B. CNA #4 Eded to put the resident to esident's gerichair was bed, the resident was earing a seat belt.  In the resident B was Ed/11 at 12:00 p.m. The the resident had resided the 2006. The resident's					

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	4/23/10 followin	ission to the facility was g hospitalization for a ft hip and left shoulder ner gerichair.					
	current goal date problem of "Risk fall r/t [related to judgement (make self, weakness regeneral health. Interventions inclimited to, getting gerichair "just be meals," "place go station for closer periods of extrenalarms to the bed.  The resident's Ca Start Date" of 3/8/24/11, indicate fall due to impair by high risk med included, but we up in gerichair place for closer observand chair." Hand	of 3/16/11, indicated a a for fall with history of a impaired safety es attempts to rise per alated to decline in Recent fall occurrence." luded, but were not gethe resident up to her affore meals, to bed after erichair near nurses observation during the restlessness," and chair and gerichair.  The Plan, with a "Problem 8/11, with goal date of the ed, "Resident is at risk for the mobility complicated ication." Approaches the not limited to, "When lace near nurses station ation" and "Alarm to bed dwritten next to the the alarm was: "5/3/11 mued]."					

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	· ·	PAC/PAB [personal alarm arm bed] - does not y self"				
	5/13/11 at 7:45 president had an usitting in the reclaresident's room. prevent further fanurse's station or immediately to be meals.  A physician's order. In the president's meals.  A physician's order. In the president had and treatment."  Emergency Room indicated, "Impresion for the president in the president had been as a proper contusion [symbol hemorrhage Additional for the president had been as a proper related to fall president for the president had been as a proper related to fall president for the president had been as a proper related to fall president for the president had an usual president for the president had an usual president for the president for the president had an usual president for the president	ol for with] intracranial dmit observation."  dicated the resident was a facility on 5/17/11.  such on the Care Plan evention indicated, pointing up]in recliner				
	r/t impaired cogr balance, osteopo	] front closure seat belt nition, unsteady gait & rosis. Ck [check] q hr, DLs may release at meals,				

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AND PLAN	OF CORRECTION	155165		LDING		05/24/2	
		100100	B. WIN		A DDDEGG CITY GTATE ZID CODE	00/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE STERN BOULEVARD		
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	activities & [sym	ibol for with]					
	supervision."						
	Interdigainliner	Team Progress Notes,					
	dated 5/16/11, in	•					
	· · · · · · · · · · · · · · · · · · ·	Team] [symbol for with]					
	1	ttorney]. On 5/13/11 at					
		ted on floor lying on left					
	_	.DNS [Director of					
	1	met [symbol for with]					
	~	all care plan & reviewed					
		appropriateness. All are					
		eel Rd would benefit					
	_ ^ ^	e] front closure seat belt					
	-	DJD [degenerative joint					
		y gait, balance, severely					
		ment & due to multiple					
		[symbol for with] MD					
		nt & all in agreement for					
		ned risks of utilizing					
	seatbelt & acknow	wledged understanding					
		reement for seat belt for					
	_	ware she is rising or					
	placing self at ris	sk for falls. New order					
	will be on re-adn	nit to have front closure					
	seat belt."						
	The Physical Res	straint Assessment, dated					
	5/17/11, indicated	d: "What are the					
	medical sympt	toms/diagnosis that					
	led to the use of	<u> </u>					
	Osteoporosis	DJD, CVA [stroke]					
		& balance, dementia.					
	unsicady gail (	x barance, ucincilla.					

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IAG	•	for physical restraint:		IAG	<i>DEI</i> 10			DATE
		seatbelt when [arrow						
		n recliner r/t unsteady						
	gait, balance, impaired cognition.							
		nour, release every 2						
		tivities of daily						
	_	ck all applicable						
	interventions							
	initiation." C	*						
	restorative measures, lowering bed							
	to floor, bed alarm, and chair alarm.							
	(Bed and chai	r alarms had been						
	`	5/3/11, prior to the						
		xed were: Medication						
	review, Conc	ave mattress,						
	Toileting prog	gram, Positioning side						
	rails, Trapeze	, Self-release belt,						
	Direct superv	ision, Drop seat,						
	Wedge cushio	on, and Sensor alarm.						
	The assessme	nt also indicated the						
	"restrictive de	evice assists the						
	resident in rea	ching his/her highest						
	level of physic	cal and psychosocial						
	functioning by	y: Decreasing his/her						
	risk from inju	ries; Assists in proper						
	body position	ing/alignment."						
	1	policy entitled						
	Physical Res	traints" was provided						
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	26RH11	Facility II	D: 000082	If continuation she	eet Pac	ne 12 of 23

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		3:00 p.m. by LPN #9.	İ		
		policy indicated,			
		se will be considered			
	only after less	restrictive measures			
		Procedure:6.			
	Restraints ca	annot be used because			
	of a family rec	quest in the absence			
	of a medical sy	-			
	During intervi	ew on 5/24/11 during			
	the Exit Confe	erence completed at			
	5:00 p.m., the	Administrator			
	indicated Resi	dent B's family was			
	very involved	in her care. The			
	Administrator	indicated the family			
	insisted on use	e of some method to			
	keep the reside	ent in her chair after			
	the fall on 5/13	3/11.			
		is related to Complaint			
	IN00090791.				
	3.1-3(w)				
	3.1-26(o)				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155165		(X2) MUI A. BUILD B. WING		NSTRUCTION  00	(X3) DATE S COMPL 05/24/20	ETED	
NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE				586 EAS	DDRESS, CITY, STATE, ZIP CODE STERN BOULEVARD SVILLE, IN47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E .	(X5) COMPLETION DATE
F0323 SS=G	environment rema hazards as is poss receives adequate devices to prevent Based on observa interview, the facts supervision to en falls did not fall the residents reviewed sample of 3. (Resustained a brain hematoma to the failed to ensure the transferred safely required by facility residents observed sample of 3. (Residents observed facility which beginn., RN #3, Un Resident B had facts at risk for falls.)	ation, record review and cility failed to provide sure a resident at risk for from her chair for 1 of 3 and related to falls in a sident B) Resident B contusion and soft tissue scalp. The facility also the resident was a using a gait belt as ty policy for 1 of 3 and during transfer in a sident B)	F03	23	F323 Accidents and Supervisit is the practice of this providensure the residents environ remains as free of accidents hazards as is possible.1. Whe corrective action will be accomplished for those reside found to have been affected the deficient practice. Therap re-screened on 6/6/11 reside and C. Seat belt(s) were dee appropriate and the least restrictive device for both resident B and C.IDT reviewed the Facare plan and C.N.A. assign sheets were appropriate for resident B and C.Resider and C were re-assessed on 6/6/11 utilizing a new Pre-Restraint Assessme and both residents will continue use of their seatbelts. Resident are reviewed every days by the IDT for ongoing of a physical restraint.On 5/1 and 5/17/11 the families of resident B and C were education the use of restraints and the	der to ment at ents by y nt B med dident all ment at B ent sue 30 use 6 /11	06/22/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	COMPLETED	
	155165		B. WIN			05/24/2	011	
	STREET ADDRESS, CITY, STATE, ZIP CODE							
NAME OF PROVIDER OR SUPPLIER			586 EA	STERN BOULEVARD				
RIVERVIEW VILLAGE				SVILLE, IN47129				
(X4) ID		STATEMENT OF DEFICIENCIES		ID		(X5)		
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION	
TAG	<b>+</b>	LSC IDENTIFYING INFORMATION)	-	TAG			DATE	
		N #3 indicated she was			risks involved. Both families agreeable and voiced	were		
	_	e time of the fall, but her			understanding of the risk			
		as the aide was preparing			involved.An In-service was			
	to lay the resider	nt down in bed, when the			conducted on 5/31/11 with th	ie		
	aide heard an em	nergency alarm sounding			nursing staff related to Falls			
	and went to answ	ver the emergency alarm.			Prevention Program and Gai			
	RN #3 indicated	she had not seen the			Policy. Both Inservices include post-tests to ensure staff	u <del>c</del> u		
	resident try to ge	et up on her own. RN #3			understanding. The in-servic	e		
	indicated the res	ident now wears a seat			wasconducted by the Staff			
	belt on her reclir	ner.			Development Coordinator.2.			
					will you identify other resider			
	On 5/23/11 at 5::	55 p.m., CNA #4 was			having the potential to be aff by the same deficient praction			
		g a resident down the			and what corrective action w			
	_	sident was reclined in a			taken.Residents with at- risk			
	<u> </u>	esident was observed to			falls have the potential to be affected by the alleged defici			
	1 -	rplish area about the size			ent			
	_	the left side of the			practice.Staff have been re-educated on the Fall			
	_	ide of the face was			Prevention Program and the	Gait		
					Belt Policy by the Staff			
	1 -	he forehead to the bottom			Development Coordinator or			
		N #3 indicated the			5/31/11.Current residents wil	'		
		sident B. CNA #4			be re-assessed for fall risk. Those identified to be at-risk	for		
		#3 she needed to put the			falls will be reviewed by the I			
		nd requested the help of			Care plans and C.N.A assign			
		ident's gerichair was			sheets will be reviewed and			
	rolled next to the	e bed, and the resident			revised as appropriate.3. W			
	was wearing a se	eat belt. The gerichair			measures will be put into pla			
	was placed in an	n upright position, and			what systemic changes you make to ensure that the defice			
	nurse and CNA g	grasped under the			practice does not recur. Staff			
	resident's arms a	nd held the back of her			been re-educated on the Fal	ı		
	pants on each sid	le as the resident was			Prevention Program and Gai			
	transferred to be	d. The resident bore			Policy by the Staff Developm Coordinator on 5/31/11.Curre			
	minimal to no w	eight during the transfer.			residents will be re-assessed			
		not used for the transfer.			fall risk. Those identified to			
	_	oom, and CNA #4			be at-risk for falls will be revi	ewed		

000082

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00 COMPLETED 05/24/2011			
		155165	B. WIN	IG		05/24/2	011
NAME OF PROVIDER OR SUPPLIER			•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
				1	STERN BOULEVARD		
RIVERV	IEW VILLAGE			CLARK	SVILLE, IN47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	provided person	al care.			by the IDT. Careplans and		
					C.N.A. sheets will be reviewed and revised as	ea	
	During interview	v at this time, CNA #4			appropriate.Residents are		
	_	s on duty when Resident			assessed for fall risk upon		
		ed her head. CNA #4			admision/re-admission, and	no	
	1	ident was in the hallway			less than quarterly or with a		
		and an emergency call			significant change. The charge	-	
	1	<b>O</b> 3			nurse implements appropriat	е	
		off. CNA #4 indicated			immediate interventions to		
		"laid back with eyes			prevent falls. The IDT team reviews falls in the morning		
		<sup>‡</sup> 4 indicated she went to			clinical meeting Monday-Frid	av	
	answer the emer	gency call light. CNA #4			(excluding Holidays) to ensu		
	indicated she go	t the other resident in the			appropriate interventions have		
	bathroom cleane	ed up, and when she came			been implemented. Those		
	out of the other	resident's room, Resident			residents at-risk are reviewed	•	
		had already been moved			the IDT for the least restrictive	e	
		NA #4 indicated the nurse			device to prevent injury. The residents plan of care and C.	NI A	
		irs," and the other CNA			assignment sheets are revise		
	1 .	sident when she fell from			needed.The DNS is respons		
					for monitor for program		
		#4 indicated the fall did			compliance.How the correcti	ve	
		ent B out. CNA #4			action will be monitored to er		
	indicated the res	ident's alarms (used to			the deficient practice will not		
	alert staff to a re	sident's rising unassisted)			recur, i.e., what quality assur		
	had been discon	tinued prior to the			program will be put into place DNS will complete the Fall at		
	resident's fall.				Falls Prevention CQI tool we		
					x 4weeks then every monthly	-	
	The clinical reco	ord for Resident B was			12 months.Data collected wil	l be	
		4/11 at 12:00 p.m. The			submitted to the CQI Commi		
		the resident had resided			for review.CQI committee wil	I	
					review the data collected		
	1	ace 2006. The resident's			determine need for further action. If thresholds is not m	et an	
		ission to the facility was			action plan will be developed		
		g hospitalization for a			improve		
	fracture to the le	ft hip and left shoulder			compliance.Non-compliance	with	
	after a fall from	her gerichair.			facility procedures may resul		
					re-education and/or disciplination	ary	

000082

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155165			LDING	NSTRUCTION  00		COMPL 05/24/2	ETED	
	PROVIDER OR SUPPLIER	₹	1	STREET A	DDRESS, CITY, STA STERN BOULE\ SVILLE, IN47129	/ARD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	LAN OF CORRECTION E ACTION SHOULD BE ID TO THE APPROPRIATE CIENCY)		(X5) COMPLETION DATE
	The resident's Pl "Problem" dated current goal date problem of "Risi fall r/t [related to judgement (mak self, weakness regeneral health. Interventions inclimited to, getting gerichair "just be meals," "place g station for closer periods of extrer alarms to the bed.  The resident's Castart Date" of 3/8/24/11, indicate fall due to impair by high risk medincluded, but we up in gerichair p for closer observand chair." Han intervention for D/C'ed [discontional datempt to rise by the resident's are the resi	an of Care, with 15/14/10, with the most of 3/16/11, indicated a k for fall with history of on impaired safety es attempts to rise per celated to decline in Recent fall occurrence." Cluded, but were not use the resident up to her effore meals, to bed after erichair near nurses or observation during me restlessness," and chair diand gerichair.  are Plan, with a "Problem 8/11, with goal date of ed, "Resident is at risk for red mobility complicated dication." Approaches are not limited to, "When clace near nurses station wation" and "Alarm to bed dwritten next to the the alarm was: "5/3/11 nued]."  der, dated 5/3/11, PAC/PAB [personal alarm larm bed] - does not y self"			action.	CIENCY)		
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	26RH11	Facility I	D: 000082	If continuation she	et Pa	ge 17 of 23

PRINTED: 06/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165		A. BUILDING		NSTRUCTION  00	(X3) DATE ( COMPL <b>05/24/2</b>	ETED	
NAME OF PROVIDER OR SUPPLIER  RIVERVIEW VILLAGE		586	EAS	DDRESS, CITY, STATE, ZIP CODE STERN BOULEVARD SVILLE, IN47129			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	(MDS) assessme indicated in the C Analysis) section [history] of recer Current meds [m or recently chang no noted side efficially to a recline when restless has would be unable far"  No documentatic 2/25/11 to 5/13/1 Team notes from indicated informates resident's tendent gerichair or decis removal of the all bed and gerichair.  Two Fall Risk Assessment and the other Fall indicated, "No" to is non-compliant non-compliance?  A Fall Circumstate 5/13/11 at 7:45 president had an unsitting in the recliner.	nt, dated 2/25/11, CAA (Care Assessment if for falls: "no HX it or frequent fall. edications] are not new ged for her, and she has ects. She is assisted up r chair for comfort, and is tendency to slide, and to prevent fall is slid too  on in Nurse's Notes from 1 or Interdisciplinary 2/25/11 to 5/13/11 eation related to the cry to slide from the sion-making on the arms from the resident's r.  ssessments, dated , were in the record. One ment indicated, "Yes," 1 Risk Assessment o the question, "Resident or has history of					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165			(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMI 05/24	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		586 EA	ADDRESS, CITY, STATE, ZIP COI STERN BOULEVARD SVILLE, IN47129	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	nurse's station or	alls indicated, "To sit at Rd [resident] placed ed [symbol for after]				
	p.m., indicated, '	ler, dated 5/13/11 at 7:50 Transfer Resident to ospital] for evaluation				
	indicated, "Impre contusion [symb	m notes, dated 5/13/11, ession: 1) Head ol for with] intracranial dmit observation."				
	5/15/11, indicate ContrastImpres hyperdensity not temporoparietal with a brain cont to focal intracere also be considered adjacent edema. localized mass enfindings are likel with the presence given the presence given the presence thematoma seen it tissues of the left large scalp soft to	ed involving the right cortex most consistent usion. Findings related bral hemorrhage may ed. There is mild There is minimal ffect in this region. These y related to head trauma e of a countercoup injury ee of a scalp soft tissue involving the scalp soft frontal region. 2. A issue hematoma is seen it tissues overlying the				

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED		
ANDILAN	or correction	155165	A. BUILDING		05/24/2011	
			B. WING STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			EASTERN BOULEVARD		
RIVERVIEW VILLAGE			CLA	ARKSVILLE, IN47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION	
PREFIX TAG			PREFI. TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
		on 5/23/11 at 8:05 p.m.,			DATE	
	_	Ianager for Hall F,				
	-	ts are to be used for all				
	transfers.					
	The facility's nol	icy related to use of gait				
		ed 5/24/11 at 3:00 p.m.				
	-	Manager for Hall C.				
	Review of the red	cord at this time				
	·	pelts are to be used at all				
		rs or mobility with the				
	exception of rece	ent surgical sites"				
	This federal tag i IN00090791.	s related to Complaint				
	3.1-45(a)(2)					
F9999						
	STATE FINDING	GS	F9999	F9990 State Finding Administration and Manage		
	3.1-13 ADMINIS	STRATION AND		is the policy of this facility to report unusual occurrences		
	MANAGEMEN	Γ		directly affect the welfare, sa		
				or health of the resident or	imited	
		r is responsible for the		residents, including but not to (D) major Accidents.1. W		
	_	ent of the facility but  as a departmental		corrective action will be		
		as a departmental sample, director of		accomplished for those residual found to have been affected		
	•	ervice supervisor, during		the deficient practice.The E.	D.	
	_	The responsibilities of		was re-educated on the Indi State Regulations related to		
				- Clare i regulatione related to		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

26RH11

Facility ID:

000082 If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155165 05/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 586 EASTERN BOULEVARD RIVERVIEW VILLAGE CLARKSVILLE, IN47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE the administrator shall include, but are not reporting (D) Major accidents on 6/10/11 by the Director of limited to, the following: Operations. 2. How will you (1) Immediately informing the division by identify other residents having the telephone, followed by written notice portential to be affected by the same deficient practice and what within twenty-four (24) hours, of unusual corrective action will be occurrences that directly threaten the taken. Residents who suffer from welfare, safety, or health of the resident or a accident have the potenital to residents, including, but not limited to, be affected by this alleged deficient practice. Major anv: accidents will be reported per (D) major accidents. State and Federal Guidelines. Each unusual occurence will be This state rule was not met as evidenced reported to the ASC Nurse by: Specialist to ensure proper reporting occurred. 3. What measures will be put into place or Based on record review and interview, the what systemic changes you will facility failed to ensure a significant injury make to ensure that the deficient practice doesn not recur. The E.D. sustained by a resident who fell was will consult with the ASC DNS reported to the Indiana State Department Specialist, and/or Director of of Health. The deficient practice affected Operations unusual occurrences 1 of 3 residents reviewed related to falls to ensure timely reporting. in a sample of 3. (Resident B) Unusual occurrences will be reported to the appropriate agency within 24 hours. The E.D Findings include: was re-educated on ASC policy regarding Unusual The clinical record for Resident B was Occurrence for Residents and Visitors. 4. How the Corrective reviewed on 5/24/11 at 12:00 p.m. The Action will be monitored to ensure record indicated the resident had resided the deficient practice will not at the facility since 2006. recur, i.e., what quality assurance program will be put into place. The E.D. will complete the A Fall Circumstance Report, dated Abuse Prohibition and 5/13/11 at 7:45 p.m., indicated the Investigation CQI tool weekly x 4 resident had an unwitnessed fall when weeks and monthly x 9 months sitting in the recliner in the hallway by the and report findings to the ASC Nurse Specialist and the CQI resident's room.

´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155165	B. WIN			05/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
חו/בט/ו	EW VILLAGE			1	STERN BOULEVARD		
	_			CLARK	SVILLE, IN47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIFY TING INFORMATION)	+	IAG	Committee. The ASC Nurse		DATE
	1 1	ler, dated 5/13/11 at 7:50 Transfer Resident to			Specialist will conduct the Ab Prohibition and Investigation tool monthly to ensure		
	[name of local ho	ospital] for evaluation			proper reporting procedures	were	
	and treatment."				followed. CQI committee will		
					review data and determine n	eed	
	Emergency Roor	n notes, dated 5/13/11,			for further action/review.		
	indicated, "Impre	ession: 1) Head					
	'-'	ol for with] intracranial					
	hemorrhage. 2) d	ementia. Admit					
	observation."						
	1	ostic Imaging, dated					
	· ·	d, "CT Head without					
	ContrastImpres						
	**	ed involving the right					
		cortex most consistent					
		usion. Findings related					
		bral hemorrhage may					
	also be considere						
	l ř	There is minimal					
		ffect in this region. These					
	_	y related to head trauma					
	1	e of a countercoup injury					
		ce of a scalp soft tissue					
		nvolving the scalp soft					
		frontal region. 2. A					
		ssue hematoma is seen					
	left frontal bone.	t tissues overlying the					
	ien irontai bone.						
	During intervious	completed on 5/24/11 at					
	_	Administrator indicated					
		ot report this incident to					
	une racinty and no	or report uns incluent to					

AND PLAN OF CO	ll l	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155165	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	05/24/	LETED
NAME OF PROVI	TIDER OR SUPPLIER		586 EA	ADDRESS, CITY, STATE, ZIP CODI STERN BOULEVARD SVILLE, IN47129	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES BY MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
the Th IN	e Indiana State	Department of Health.  is related to Complaint				